ATTACHMENT A

Los Angeles County
Department of Health Service
Emergency Medical Services Agency
Sexual Assault Response Team Center

GENERAL INFORMATION

Name of Hospital:_____

Address:_____

Telephone:_____

Please submit a copy of:

- State Department of Health Services License (DHS)
- Accreditation from Joint Commission of Accreditation of Healthcare Organizations (JCAHO)
- Permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5, California Code of Regulations

ADMINISTRATION/COORDINATION

Chief Executive Officer:_____Telephone_____

SART Program Director:_____ Telephone_____

SART Medical Director:_____ Telephone_____

SART Center Coordinator:_____ Telephone_____

MEDICAL ADVISOR

Name: _____

Board Certified in: _____

Board Certification Expiration Date: _____

Board Certification Number: _____

If not Board Certified, eligible to take Board Certification in _____
Please send a copy of the Medical Advisor's Certification.

SART CENTER PROGRAM DIRECTOR

Name_____

Nursing License Number_____ Expiration date 1/26/2010

Completion Date of Sexual Assault Examiner Course_____

SART CENTER COORDINATOR

Name_____

Nursing License Number_____ Expiration date_____

Completion Date of Sexual Assault Examiner Course_____

ADVOCATE

Name of the Rape Crisis Center:_____

Crisis Center Director:_____

Please submit:

1. Documentation of OCJP training

2. A sample page of the log book and staff/volunteer schedule or other documentation indicating 24- hour availability. At the time of the survey, have available the log book and staff/ volunteer schedule or other documentation indicating 24 hour availability for the past 6 months.

PERSONNEL-Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner

Name	MD/RN License Expiration Date	Completion date of SART examiner course